Giardiasis

CASE

Case Name

Last name: _____ Suffix: ☐ Jr. ☐ Sr. ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ VI

First name: _____ Alias: _____

Middle name: _____

Case Address

Address line 1: _____

Address line 2: _____

ZIP code: _____ State: _____

City: _____ County: _____

Long-term care resident: ☐ Yes ☐ No *If yes,* Facility name: _____

Case Demographic Information

Date of birth: ___/___/___ Estimated? ☐

Country of birth: _____

Gender: ☐ Female ☐ Male ☐ Other

If female, pregnant?: ☐ Yes ☐ No ☐ Unknown

If pregnant, est. delivery date: ___/___/___

Case Demographic Information, continued

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with Partner ☐ Widowed

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Case's Parent / Guardian

First name: _____ Last name: _____

Phone

Belongs to: ☐ Case ☐ Parent/Guardian

Phone 1: (___) ___-___ Ext.: _____

Type: ☐ Home ☐ Cell ☐ Work/Office ☐ Other _____

Belongs to: ☐ Case ☐ Parent/Guardian

Phone 2: (___) ___-___ Ext.: _____

Type: ☐ Home ☐ Cell ☐ Work/Office ☐ Other _____

Belongs to: ☐ Case ☐ Parent/Guardian

Phone 3: (___) ___-___ Ext.: _____

Type: ☐ Home ☐ Cell ☐ Work/Office ☐ Other _____

Please list additional parents/guardians in the Notes section at the end of the form, if needed.

EVENT

Event Onset

Diagnosis date: ___/___/___ Onset date: ___/___/___

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Date of death: ___/___/___

Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes ☐ Year-end reconciliation

Public Health (PH) Investigation Initiation

Date PH consulted healthcare provider: ___/___/___

Date PH first attempted to contact patient: ___/___/___

Was patient educated on disease prevention and control measures? ☐ Yes ☐ No

Outbreak/Exposure

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Healthcare Provider

Last name: _____

First name: _____

Title: ☐ ARNP ☐ DO ☐ MD ☐ NP ☐ PA

Healthcare Provider Facility

Facility name: _____

Address line 1: _____

Address line 2: _____

ZIP code: _____ City: _____

State: _____ County: _____

Phone: (___) ___-___ Ext: _____

If yes, Outbreak name: _____

Exposure setting: _____

Epidemiologically linked: ☐ Yes ☐ No ☐ Unknown

Type: ☐ Home ☐ Cell ☐ Work/Office ☐ Other _____

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation' (e.g. attends school, nurse, retired)

Occupation

Occupation type: _____

Job title: _____

Facility name: _____

Address line 1: _____

Address line 2: _____

ZIP code: _____ City: _____ State: _____

County: _____

Phone: ( ) - Ext.: _____

Type: ☐ Home ☐ Cell ☐ Work/Office ☐ Other: _____

Occupation Dates

Worked after symptom onset: ☐ Yes ☐ No ☐ Unk

Removed from duties due to this illness: ☐ Yes ☐ No ☐ Unk

Date removed due to this illness: / /

In this occupation, does the Case:

Handle food: ☐ Yes ☐ No ☐ Unk

Attend or provide child care: ☐ Yes ☐ No ☐ Unk

Attend or teach school: ☐ Yes ☐ No ☐ Unk

Work in a health care setting: ☐ Yes ☐ No

If Yes, health care worker type:

☐ Health Care Provider (e.g. Physician, nurse)
☐ Laboratory
☐ Environmental Services
☐ Other *specify*: _____

If Yes, direct patient care duties? ☐ Yes ☐ No ☐ Unk

HOSPITALIZATIONS

Was the Case hospitalized due to this illness? ☐ Yes ☐ No ☐ Unknown

Still hospitalized at the time of this interview? ☐ Yes ☐ No ☐ Unknown

Hospital: _____

Admission date: / / Discharge date: / / Days hospitalized: _____

CLINICAL INFO & DIAGNOSIS

Symptoms:	Yes	No	Unk	*If yes,* complete :
Diarrhea	☐	☐	☐	Onset date: / / Duration: ☐ Hours ☐ Days
Bloating	☐	☐	☐	
Malabsorption	☐	☐	☐	
Abdominal cramps	☐	☐	☐	
Unexplained Weight Loss	☐	☐	☐	Weight Lost: _____ lbs/Kg

Other: _____

Date returned to normal activities: / /

Symptoms ongoing at time of interview: ☐ ☐

TREATMENT

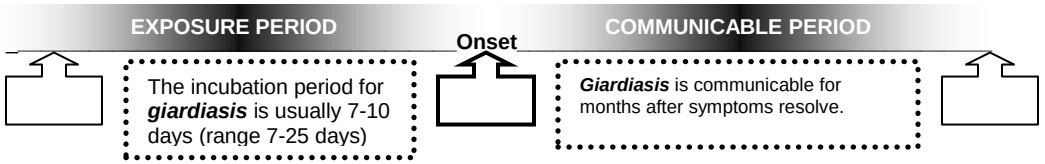
Medications prescribed? ☐ Yes ☐ No ☐ Unk

If yes:

Medication	Medication	Medication
☐ Albendazole ☐ Paromomycin ☐ Furazolidone ☐ Quinacrine ☐ Metronidazole ☐ Tinadazole ☐ Nitazoxanide ☐ Other _____	☐ Albendazole ☐ Paromomycin ☐ Furazolidone ☐ Quinacrine ☐ Metronidazole ☐ Tinadazole ☐ Nitazoxanide ☐ Other _____	☐ Albendazole ☐ Paromomycin ☐ Furazolidone ☐ Quinacrine ☐ Metronidazole ☐ Tinadazole ☐ Nitazoxanide ☐ Other _____
Date started: / /	Date started: / /	Date started: / /
Dose: _____ Unit: ☐ mg ☐ ml ☐ IU	Dose: _____ Unit: ☐ mg ☐ ml ☐ IU	Dose: _____ Unit: ☐ mg ☐ ml ☐ IU

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

In the 25 days prior to onset of symptoms did the Case:

Travel within Iowa? ☐ Yes ☐ No ☐ Unk	City within Iowa: _____	Departure date: / /	Return date: / /
Travel within U.S.? ☐ Yes ☐ No ☐ Unk	State: _____ City: _____	Departure date: / /	Return date: / /
Travel outside U.S.? ☐ Yes ☐ No ☐ Unk	Country: _____	Departure date: / /	Return date: / /

WATER EXPOSURES

In the 25 days prior to onset of symptoms did the Case drink well water?: ☐ Yes ☐ No

If Yes, where ?: ☐ *Home* ☐ *Work* ☐ *School* ☐ *Child care* ☐ *Other specify:* _____

In the 25 days prior to onset of symptoms did the Case drink from a stream or other untreated water source?: ☐ Yes ☐ No

If Yes, where?: _____

Did the Case swim in the 25 days prior to onset of symptoms?: ☐ *Yes* ☐ *No*

If yes, complete the following:

Water Type	**Date Swam** *List date of each visit separately*	**Location name, Address, City, State, ZIP, County**
Swim in chlorinated water *i.e. pool, spa*	Visit 1: ___/___/___	
	Visit 2: ___/___/___	
	Visit 3: ___/___/___	
	Add additional visits to the Notes section	
Swim in unchlorinated water *i.e. river, lake, pond, unchlorinated kiddie pool*	Visit 1: ___/___/___	
	Visit 2: ___/___/___	
	Visit 3: ___/___/___	

OTHER EXPOSURES

In the 25 days prior to onset of symptoms did the Case:

Wear diapers: ☐ Yes ☐ No ☐ Unk
Have contact with diapers: ☐ Yes ☐ No ☐ Unk

CONTACTS ***Reminder: Each contact must be entered as a new case in IDSS and interviewed.***

Are there contacts of the Case with similar symptoms? ☐ Yes ☐ No ☐ Unk

If yes, list contacts of the Case with similar symptoms:

First name: ____________ Last name: ____________
Symptom onset date: / /

Relationship to case:
☐ Family member (household)
☐ Family member (non-household)
☐ Roommate
☐ Sexual contact/ Significant other
☐ Friend/acquaintance
☐ Contact- work/school/etc.

Reminder: This contact must be entered as a new case in IDSS and interviewed.

First name: ____________ Last name: ____________
Symptom onset date: / /

Relationship to case:
☐ Family member (household)
☐ Family member (non-household)
☐ Roommate
☐ Sexual contact/ Significant other
☐ Friend/acquaintance
☐ Contact- work/school/etc.

Reminder: This contact must be entered as a new case in IDSS and interviewed.

First name: ____________ Last name: ____________
Symptom onset date: / /

Relationship to case:
☐ Family member (household)
☐ Family member (non-household)
☐ Roommate
☐ Sexual contact/ Significant other
☐ Friend/acquaintance
☐ Contact- work/school/etc.

Reminder: This contact must be entered as a new case in IDSS and interviewed.

NOTES: